

WHEA Lunch and Learn December 2016

Patient Safety Chapter: Not Just for Nursing

Marge McFarlane, PhD, MT(ASCP), CHFM, CHSP, CJCP, HEM, MEP Superior Performance, LLC *mcfarlane.marge@gmail.com*

Have Questions??

During the Live Webinar:

Click on "chat" in the lower right hand corner

If viewing the posted webinar: Call Marge McFarlane at 715-835-3730 or email at *mcfarlane.marge@gmail.com* Ask a question now via Chat

Learning Objectives

- Identify key elements of the patient safety chapter that relate to facilities and the environment of care
- Discuss strategies for identifying opportunities for improvement
- Link findings to performance improvement activities

Our Mission

Responsibilities:

- legal
- regulatory
- fiscal
- ethical



To design and maintain a safe environment for patients, their family, staff and practitioners

Partner with IP and enforce hand hygiene programs – every person, every task, every day

The JC Patient Safety Chapter

Initially released in 2015

No new standards or elements of performance Outlined strategies and processes

Align all hospital leadership, staff, providers, patients and families toward a sustained culture of patient safety

Patient Safety Systems

- Proactive approach for designing or redesigning a patient centered system
- Core value of The Joint Commission: to improve quality of care and patient safety
- Goal of "0" harm
- Events may still occur with minimal harm



First Obligation of Healthcare "Do No Harm"

- Align standards with daily work to engage all staff and patients to reduce harm
- Advance knowledge, skills and competence of staff and patients to improve quality & safety
- Proactive quality approach to increase accountability, trust and knowledge while reducing the impact of fear and blame



Quality Management System

- Ensures reliable processes
- Decrease variation and waste
- Focuses on better outcomes
- Uses evidence to ensure service is satisfactory
- Reduces/eliminates system failures and human errors that may cause harm to patients, families and staff



Variation

Common Cause Variation :

random, frequent and generally present in the process

Special Cause Variation:

rare and due to a specific event



Getting to Work On Time...





Definitions

- Patient Safety Event: event, incident or condition that *could* have resulted or *did* result in harm to a patient
- Adverse Event: A patient safety event that resulted in harm to a patient
- Sentinel Event: A patient safety event that reaches the patient and causes death, permanent harm or severe temporary harm

Definitions (continued)

- Close Call ("near miss", "no harm", "good catch"): A patient safety event that did not cause harm as defined by the term sentinel event
- Hazardous or "unsafe" conditions: a circumstance that increases the probability of an adverse event



Integrated Patient Safety System

Staff and leaders work to:

- Eliminate complacency
- Promote collective mindfulness
- Treat each other with respect and compassion
- Learn from patient safety events, including close calls and other system failures that have not caused patient harm



Integrated Approach

- Requires strong leadership support
- Safety culture
- Validated methods to improve processes and systems
- Standardized ways for interdisciplinary teams to communicate and collaborate



• Safety integrated technologies

Learning Organizations

- Team learning
- Shared visions and goals
- Shared mental model (similar ways of thinking)
- Individual commitment to life long learning
- Systems thinking



Learning Organizations

- Patient safety events seen as opportunities for learning and improvement
- Transparent, non-punitive approach to reporting
- Collectively learn from patient safety events
- Fair and just safety culture
- Strong reporting systems/commitment to data

Reporting Events

- <u>Every</u> patient safety event must be reported
- Define problem
- Identify solutions
- Achieve sustainable results
- Disseminate the changes or lessons learned to the rest of the hospital



Hospital Leaders

- Promote learning
- Motive staff to uphold a fair and just safety culture
- Transparent environment
- Model professional behavior
- Remove intimidating behavior that might prevent safe behaviors
- Provide resources and training



Fair and Just Culture

- Not "blame-free" culture
- Balances learning with accountability
- Assess errors and patterns of behavior in a consistent manner with goal of eliminating behaviors that undermine a culture of safety
- Clear, equitable and transparent process for recognizing and separating blameless errors from reckless or unsafe acts

Data and Reporting Systems

- Robust reporting system
- Use of measurement for improvement
- Learn collectively from adverse events, close calls and hazardous conditions
- Proactive vs. reactive assessments
- Identify problems, prioritize issues, develop solutions and track to determine success



Centers for Medicare and Medicaid

§482.21 Condition of Participation: Quality Assessment and Performance Improvement Program (QAPI)

... The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement)... The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

Chapters for Patient Safety

- Environment of Care (EC)
- Infection Control (IC)
- Leadership (LD)
- Life Safety (LS)
- Medication Management (MM)
- Provision of Care (PC)
- Performance Improvement (PI)
- Patients Rights (RI)

Write "reports" using "data" Figure 1. How awesome we are

freshspectrum.com

Deleted 51 EPs Phase II 2017

- Additional EPs deleted as duplicative or similar to, implicit in, or duplicative of other existing EPs
- Address issues that have been covered by standards for many years
- Now a routine part of operations or clinical care processes, so they no longer need to be addressed in standards.
- Some of them no longer address contemporary quality and safety concerns.
- EPs adequately addressed by law and regulation or other external requirements, so separate Joint Commission requirements are not needed, example reporting harm from medical equipment

Scoring Changes

- All "A" and "C" scores and direct and indirect findings have been eliminated
- PFI eliminated August 2016
- SAFER Matrix adopted for assessment of risk of finding based on frequency and severity of harm
- A Condition Level Deficiency (CLD) or immediate threat to life citation will result in a potential follow-up survey by TJC and/or CMS

A New SAFER Model



Analyzing Data

- Effective data analysis can "diagnose" system problems just as one could diagnose patient problems
- Monitor performance
- Detect variation
- Identify opportunities for improvement



Proactive Approach

- Evaluate process to see how it could potentially fail
- Understand consequences of such a failure
- Identify parts of the process that need improvement
- Proactive risk assessment increases understanding about the complexities of process and design management



Proactive Risk Assessment

- Identification of actionable common causes
- Avoidance of unintended consequences
- Identification of commonalities across departments/services/units
- Identification of systems solutions



- Proactive approach to reduce harm
- Identify in the design of new processes



- Any circumstance that increases the probability of a patient safety event
- May be the result of human error or violation, design flaw in the systems or arise in a system in changing circumstances

- Human error- skills based, decision based or knowledge based
- Violations routine (intentional) or exceptional (negligent)
 - Routine violation may break established rules or policies and yet be a common practice
 - Exceptional violation is willful behavior outside the norm that is not condoned by management

- Preconditions noise, clutter, wet floors, etc., inadequate staffing levels, an operator who is impaired or inadequately trained
- Supervisory Influences inadequate supervision, planned inappropriate operations, failure to address a known problem, authorization of activities that are known to be hazardous



Operational Influences -

- Inadequate staffing
- Inadequate policies
- Lack of strategic risk assessment



EC 04.01.01 The hospital establishes a process for continually monitoring, internally reporting and investigating the following: (*revised language*)

- Injuries to patients or others within the facilities
- Occupational illnesses and staff injuries
- Incidents of damage to its property or the property of others
- Security incidents involving patients, staff, or others within its facilities





EC 04.01.01

- Hazardous materials/waste spills/exposures
- Fire safety management problems/deficiencies/failures



- Medical or lab equipment management problems, failures, and use errors
- Utility systems management problems, failures, or use errors



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EC Data

- Periodic rounding- *no longer required*
 - Every six months in patient care areas
 - Annual in non-patient care areas
- Daily for construction projects
- General conditions
 - Wet floors, icy or uneven sidewalk
 - Incoming shipments in exit corridors
 - Folded entryway rugs





EC.02.02.01

 Labels on roof vents for waste anesthesia gas disposal system (WAGD), isolation rooms and laboratory hoods



• Always been part of NFPA 99



EC.02.03.03 Fire Drills NFPA 99 - 2012

- Written procedures are required for OR and surgical suite emergencies, 15.13.3.9
- Fire exit drills are required to be conducted annually in ORs and surgical suite locations, 15.13.3.10.3
- Unexpected times and varying locations
- CMS requires initial and annual documented fire response training for all staff for critical access hospitals

new as of 11/16

Hyperbaric Chambers

- NFPA 99-2012 Chapter 14
- HBO emergency procedures and annual fire drills shall be documented (14.3.1.4.5)
- Training for EVS and HBO cleaning whether the chamber is used or not (14.3.6.4)



EC.02.05.01

- Accurate legends on electrical panels
- Fire alarm circuit identified in RED
- Restricted access to panel with fire alarm circuit
- All ventilation findings moved to this standard (critical/non-critical areas)
- Generator environment requirements for ambient temperature, water jacket temperature, and room ventilation

EC.02.05.05 EP 1 *new EP*

When performing repairs or maintenance activities, the hospital has a process to mange risks associated with air-quality, infection control, utility requirements, now odor, dust, vibration and other hazards that affect care, treatment or services for patients, staff and visitors.



Planning for Maintenance Activities

- Consider Facility Modification Risk Assessment form
- Identify categories of routine maintenance
- Consider infection prevention protocols for different patient areas
- Ensure all transmission based precautions are followed





Transmission Based Precautions

Stand Alone Projects

- "git r done"
- Environments may be harder to isolate
- Seems to take more time to set up containment than the project itself
- Most often performed in-house
- A risk assessment often not completed
- Perceived as an irritation to staff
- A disruption to normal traffic flow
- Healthcare uses room/area pressurization as an engineering control





EC.02.05.07 NFPA 110 - 2010

- Generator annual load test 90 minutes.
 50% load 30 min., 75% load 60 min.,
 25% load test eliminated, 8.4.2.3
- Weekly inspections permit conductance testing in lieu of specific gravity, if the batteries are maintenance-free, 8.3.7.1
- Fuel quality test required annually for emergency generator, ASTM methods, 8.38

LS.02.01.20 and 34

- Suites separations and subdivisions
- Wheeled equipment/fixed furnishings
- Corridor projections 4" per ADA
- Multiple delayed egress paths if sprinklered
- Ceiling membranes intact
 - No missing or broken ceiling tiles



LS.02.01.35

- Escutcheon plates must be installed
- 6 spare sprinkler heads of the correct type
- Closets may not require sprinklering
 - -based on sq. ft.
- Fire extinguisher mounting
- K-class fire extinguishers placard requirements



EC.04.01.03 The hospital analyzes identified environment of care issues

EP 2 Uses the results of data analysis to identify opportunities to resolve environmental safety

issues.



Eps 1 and 3 eliminated as

implied – identifies participants of the process

EC.04.01.05

EP 1 Identifies and analyzes problematic trends related to the environment of care



PI.01.01.01 and PI.03.01.01

- The hospital collects data to monitor its performance
- The hospital improves performance on an ongoing basis

CMS CoP: That adequate resources are allocated for measuring, assessing, improving, and sustaining the hospital's performance and reducing risk to patients



LD.04.01.05

EP 4 Staff are held accountable for their responsibilities

Everyone works together for a safe environment All equipment and life safety testing, inspection and maintenance documents are completed on time and readily available.

TJC no longer allows lack of readily available test documents to be clarified.

OSHA Inspections

New National Emphasis Program

- Slips, trips and falls
- Ergonomics related to patient handling
- TB/Respiratory Protection
- Workplace Violence
- Blood Borne Pathogens
- Also: Hazcom and MDROs (Multidrug resistant organisms)





New Federal Budget Bipartisan Budget Act 2015

Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015

- First change to OSHA penalties since 1990
- Federal Civil Penalties Inflation (CPI) Adjustment Act Improvements Act 2015 – Section 701 (b)
- Catch up calculations in 2016 capped at 150%
- Other than serious : was \$1000, now \$1517
- Serious: was \$7000, now \$10,616
- Willful: was \$70,000, now \$106,158

Summary

- Collect and analyze data
- Identify sustainable approaches
- Implement across the organization
- Educate, educate, educate
- Eliminate complacency

For safe patient care, every person, every task, every day!

Questions?

Marge McFarlane, PhD, MT(ASCP), CHFM, CHSP, CJCP, HEM, MEP <u>mcfarlane.marge@gmail.com</u> Superior Performance, LLC www.margemcfarlane.com